		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042614

Facility Name: Golfview Developmental Center

Address: 9555 West Golf Road (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847)827-6628 **Fax #** (847)827-0948

IDPA ID Number: 362935353001

Date of Initial License for Current Owners: 11/17/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		x	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Kenneth Pinsky **Telephone Number:** (847)267-9600
Warady & Davis LLP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Warady & Davis LLP, 1717 Deerfield Road, Suite 300 So., Deerfield, IL 60015
(Telephone) (847)267-9600 Fax # (847)267-9696

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	135	Intermediate/DD	135	49,275	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	47,601			47,601	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,601			47,601	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.60%

D. How many bed-hold days during this year were paid by the Department? 1,019 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 11/17/97

J. Was the facility purchased or leased after January 1, 1978? YES [X] Date 11/17/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	289,431	30,558	7,307	327,296		327,296		327,296			1
2	Food Purchase		182,352		182,352		182,352		182,352			2
3	Housekeeping	368,555	56,508		425,063		425,063		425,063			3
4	Laundry	55,055	1,805		56,860		56,860		56,860			4
5	Heat and Other Utilities			215,775	215,775		215,775		215,775			5
6	Maintenance	64,580	27,275	123,950	215,805		215,805		215,805			6
7	Other (specify):*											7
8	**TOTAL General Services**	777,621	298,498	347,032	1,423,151		1,423,151		1,423,151			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,064,135	47,576	230,910	2,342,621		2,342,621		2,342,621			10
10a	Therapy			16,760	16,760		16,760		16,760			10a
11	Activities	88,690	3,418	45,061	137,169		137,169		137,169			11
12	Social Services	13,654		6,438	20,092		20,092		20,092			12
13	CNA Training	102,151			102,151		102,151		102,151			13
14	Program Transportation					14,603	14,603		14,603			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,268,630	50,994	311,169	2,630,793	14,603	2,645,396		2,645,396			16
	C. General Administration											
17	Administrative	173,904		431,692	605,596		605,596	(431,692)	173,904			17
18	Directors Fees											18
19	Professional Services			400,322	400,322		400,322		400,322			19
20	Dues, Fees, Subscriptions & Promotions			74,882	74,882		74,882	(118)	74,764			20
21	Clerical & General Office Expenses	153,348	27,467	80,253	261,068		261,068	(1,491)	259,577			21
22	Employee Benefits & Payroll Taxes			717,024	717,024		717,024	(41)	716,983			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,448	1,448		1,448		1,448			24
25	Other Admin. Staff Transportation			19,470	19,470	(14,603)	4,867		4,867			25
26	Insurance-Prop.Liab.Malpractice			91,957	91,957		91,957	45,454	137,411			26
27	Other (specify):*											27
28	**TOTAL General Administration**	327,252	27,467	1,817,048	2,171,767	(14,603)	2,157,164	(387,888)	1,769,276			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,373,503	376,959	2,475,249	6,225,711		6,225,711	(387,888)	5,837,823			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Golfview Developmental Center #0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,218	23,218		23,218	340,459	363,677			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,033	35,033		35,033	498,050	533,083			32
33	Real Estate Taxes							252,743	252,743			33
34	Rent-Facility & Grounds			1,180,383	1,180,383		1,180,383	(1,180,383)				34
35	Rent-Equipment & Vehicles			46,162	46,162		46,162	(1,270)	44,892			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,284,796	1,284,796		1,284,796	(90,401)	1,194,395			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,356		1,356		1,356		1,356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			419,862	419,862		419,862		419,862			42
43	Other (specify):*			2,534	2,534		2,534	(2,534)				43
44	**TOTAL Special Cost Centers**		1,356	422,396	423,752		423,752	(2,534)	421,218			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,373,503	378,315	4,182,441	7,934,259		7,934,259	(480,823)	7,453,436			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	881	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(11,762)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,184)	43		19
20	Contributions	(1,050)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(200)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(434,712)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (448,027)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(32,797)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (32,797)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (480,824)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Management Fees	$ (431,692)	17	1
2	Dues and Subscriptions	(118)	20	2
3	Finance Charges	(100)	43	3
4	Gifts	(41)	22	4
5	Bank Charges	(1,491)	21	5
6	Rental Expense	(1,270)	35	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(434,712)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(431,692)	0	0	0	0	0	0	0	0	0	0	(431,692)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(118)	0	0	0	0	0	0	0	0	0	0	(118)	20
21	Clerical & General Office Expenses	(1,491)	0	0	0	0	0	0	0	0	0	0	(1,491)	21
22	Employee Benefits & Payroll Taxes	(41)	0	0	0	0	0	0	0	0	0	0	(41)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	45,454	0	0	0	0	0	0	0	0	0	45,454	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(433,342)	45,454	0	0	0	0	0	0	0	0	0	(387,888)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(433,342)	45,454	0	0	0	0	0	0	0	0	0	(387,888)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	881	339,577	0	0	0	0	0	0	0	0	0	340,458	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,762)	509,812	0	0	0	0	0	0	0	0	0	498,050	32
33	Real Estate Taxes	0	252,743	0	0	0	0	0	0	0	0	0	252,743	33
34	Rent-Facility & Grounds	0	(1,180,383)	0	0	0	0	0	0	0	0	0	(1,180,383)	34
35	Rent-Equipment & Vehicles	(1,270)	0	0	0	0	0	0	0	0	0	0	(1,270)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,151)	(78,251)	0	0	0	0	0	0	0	0	0	(90,402)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):* **See Sec. VI**	(2,534)	0	0	0	0	0	0	0	0	0	0	(2,534)	43
44	**TOTAL Special Cost Centers**	(2,534)	0	0	0	0	0	0	0	0	0	0	(2,534)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(448,027)	(32,797)	0	0	0	0	0	0	0	0	0	(480,824)	45

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bertram Miner	100			Golfview Realty Partnership d/b/a Golfview Partnership Venture	Chicago	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$	Golfview Realty Partnership	100.00%	$ 45,454	$ 45,454	1
2	V	30	Depreciation		Golfview Realty Partnership	100.00%	339,577	339,577	2
3	V	32	Interest Expense		Golfview Realty Partnership	100.00%	512,167	512,167	3
4	V	33	Real Estate Taxes		Golfview Realty Partnership	100.00%	252,743	252,743	4
5	V	32	Interest Income	2,355	Golfview Realty Partnership	100.00%		(2,355)	5
6	V	34	Rent Expense	1,180,383	Golfview Realty Partnership	100.00%		(1,180,383)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,182,738			$ 1,149,941	$ * (32,797)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Anthony Miner*	President	Administrator	None	None	70-80	100.00	Salary	$ 92,465	17, 1	1
2											2
3	*Son of Bertram Miner										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 92,465		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capstone Realty Advisors		X	Mortgage	$48,209.00	4/17/03	$ 9,225,000	$ 9,053,351	5/31/2043	5.6000	$ 508,787	1
2	Capstone Realty Advisors		X	Mortgage Costs							3,380	2
3	First Insurance Funding Corp		X	Insurance Financing							522	3
4	Interest Income Offset		X								(2,651)	4
5	Shareholder Loan	X		Working Capital	Interest Only	Various	786,009	777,009	Demand	9.0000	34,807	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,209.00		$ 10,011,009	$ 9,830,360			$ 544,845	9
	B. Non-Facility Related*											
10	Shareholder Loan	X		Working Capital - Excess interest over Prime paid to related party							(11,762)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,762)	14
15	TOTALS (line 9+line14)						$ 10,011,009	$ 9,830,360			$ 533,083	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 45,454** **Line # 26**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	126,765	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	246,770	2
3. Under or (over) accrual (line 2 minus line 1).	$	120,005	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	132,738	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	252,743	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	271,018	8
	2001	224,336	9
	2002	223,514	10
	2003	230,482	11
	2004	241,341	12

2004 Tax Assessment 241,341
5% Increase x1.05
2004 Estimated Taxes 253,408
Use 132,738 ($253,408 less $120,670 paid 12/20/04)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1600.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Cente COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042614

CONTACT PERSON REGARDING THIS REPORT Anthony Miner

TELEPHONE (847)827-6628 FAX #: (847)827-0948

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-100-012-0000	9555 Golf Road, Des Plaines, IL	$ 23,113.10	$ 23,113.10
2.	09-15-100-013-0000	9555 Golf Road, Des Plaines, IL	$ 218,227.84	$ 218,227.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 241,340.94	$ 241,340.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential Care	117,000	1977	$ 234,000	1
2					2
3	TOTALS	117,000		$ 234,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1997	1997	$ 8,641,370	$	40	$ 216,034	$ 216,034	$ 1,746,328	4
5			1997		(580,616)		39	(14,888)	(14,888)	(112,426)	5
6			1998		40,292		40	1,007	1,007	7,554	6
7	7		1999	1999	52,495		40	1,312	1,312	8,529	7
8											8
	Improvement Type**										
9	Fencing			1997	1,200	120	10	120		1,020	9
10	Lobby notice board			1998	3,380	338	10	338		2,535	10
11	Parking Lot			1998	139,900		15	9,327	9,327	69,951	11
12	Exhaust system			1999	2,801		10	280	280	1,820	12
13	Compressor			1999	11,972		10	1,197	1,197	7,782	13
14	Fencing			1999	1,800		10	180	180	1,170	14
15	Fire Vents			1999	1,806		10	181	181	1,175	15
16	Elevator			1999	932		10	93	93	606	16
17	Security system			1999	970		10	97	97	631	17
18	Heating Unit			2000	715		10	72	72	394	18
19	Security system			2000	2,017		10	202	202	1,110	19
20	Telephone Line			2000	7,234		10	723	723	3,978	20
21	Security system			2000	2,087	208	10	208		1,146	21
22	Specialty wiring & Oxygen Lines			2001	567,060		10	56,706	56,706	283,530	22
23	Security system			2001	4,803	480	10	480		2,161	23
24	Security system			2001	17,731	1,773	10	1,773		7,979	24
25	Fire alarm system			2001	7,583	758	10	758		3,412	25
26	Security system			2002	4,402	440	10	440		1,540	26
27	Hot Water Tanks			2002	3,142	314	10	314		1,099	27
28	Hot Water Pipes			2003	9,150	915	10	915		2,440	28
29	Title and Wall Coverings			2003	4,190	419	10	419		978	29
30	Door			2003	3,624	362	10	362		844	30
31	Resident Room Repair			2003	5,314	531	10	531		1,062	31
32	2 new faucets			2003	2,308	231	10	231		462	32
33	Floor Repair			2004	5,966	597	10	597		1,094	33
34	Drywall			2004	6,749	675	10	675		1,237	34
35	Repair Walls			2004	15,133	1,513	10	1,513		2,020	35
36	Dishwasher			2004	2,850	285	10	285		404	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hot Water Piping	2004	$ 3,458	$ 346	10	$ 346	$	$ 404	37
38	Entry Systems	2005	3,700	370	10	370		370	38
39	HVAC Repairs	2005	20,122	671	10	671		671	39
40	Flooring	2005	2,290	19	10	19		19	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,019,930	$ 11,365		$ 283,888	$ 272,523	$ 2,055,029	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 922,181	$ 10,475	$ 78,538	$ 68,063	5-10 years	$ 759,560	71
72	Current Year Purchases	19,038	1,436	1,436		5-10 years	1,436	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 941,219	$ 11,911	$ 79,974	$ 68,063		$ 760,996	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,195,149	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,276	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 363,862	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 340,586	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,816,025	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 9,983 Description: Copier $5,738; Postage Meter $380; Ice Machine $3,720; Barbeque $145
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transport	2000 Ford Econo Van	$ 634.00	$ 6,338	17
18	Resident Transport	2003 Ford Econo Van	550.00	5,499	18
19	Resident Transport	2003 Ford Econo Wagon	651.00	7,160	19
20	See Attached schedule 14a			15,914	20
21	TOTAL		$ #######	$ 34,911	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2005

Schedule 14a

Page 14 - Vehicle Rental

Use	Model Year & Make	Monthly Lease Payment	Rental Expense for this period
Resident Transportation	2004 Ford Econoline Van	604.00	6,644
Resident Transportation	2006 Ford Econoline Van	635.00	1,905
Resident Transportation	2006 Ford Econoline Van	635.00	1,905
Administrative	2003 Acura	455.00	5,460
			15,914

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	900	825		1,725
3	Classroom Wages (a)	10,678	11,568		22,246
4	Clinical Wages (b)	23,767	25,747		49,514
5	In-House Trainer Wages (c)	18,730	20,432		39,162
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 54,075	$ 58,572	$	$ 112,647
10	SUM OF line 9, col. 1 and 2 (e)	$ 112,647			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	36
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	33
2. From other facilities (f)	
TOTAL TRAINED	69

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L39, C2	visits				460		460	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Optical	L39, C2					896		896	13
14	TOTAL			$		$	$ 1,356		$ 1,356	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,854	$ 36,819	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,901,751	1,901,751	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,822	28,701	6
7	Other Prepaid Expenses	24,360	24,360	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17a		61,703	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,939,787	$ 2,053,334	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		234,000	13
14	Buildings, at Historical Cost		8,710,554	14
15	Leasehold Improvements, at Historical Cost	130,443	270,344	15
16	Equipment, at Historical Cost	150,850	941,219	16
17	Accumulated Depreciation (book methods)	(115,853)	(2,809,109)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,025	526,382	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 166,465	$ 7,873,390	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,106,252	$ 9,926,724	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 412,155	$ 412,155	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,578	259,578	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		132,738	32
33	Accrued Interest Payable	8,347	8,347	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17a	3,329,349	2,981,419	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,009,429	$ 3,794,237	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,053,351	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,053,351	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,009,429	$ 12,847,588	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,903,177)	$ (2,920,864)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,106,252	$ 9,926,724	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2005

Schedule 17a

Page 17 - Balance Sheet	**Operating**	**After Consolidation**
Line 9 - Other Current Assets		
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	61,703
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	404,910
Deposits	1,025	1,025
Mortgage Costs, net	-	120,447
	1,025	526,382
Line 36 - Other Current Liabilities		
Due to Shareholders	777,009	777,009
Provider Participation Fees Payable	217,974	217,974
Due to 3rd-Party Payor	267,413	267,413
Accrued Management Fees	1,719,023	1,719,023
Due to Affiliates	347,930	-
	3,329,349	2,981,419

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,067,867)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,067,867)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(835,310)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (835,310)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,903,177)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,876,941	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,876,941	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	74,820	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 74,820	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Early Discharge	147,188	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 147,188	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,098,949	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,423,151	31
32	Health Care	2,630,793	32
33	General Administration	2,171,767	33
	B. Capital Expense		
34	Ownership	1,284,796	34
	C. Ancillary Expense		
35	Special Cost Centers	3,890	35
36	Provider Participation Fee	419,862	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,934,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	(835,310)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (835,310)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2005

Schedule 19a

Net loss for the year per page 19 does not agree to taxable loss on the Federal Income Tax Return because this entity is a cash basis taxpayer.

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,191	1,333	$ 33,542	$ 25.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,334	1,500	30,672	20.45	3
4	Licensed Practical Nurses	8,634	9,413	213,612	22.69	4
5	CNAs & Orderlies	2,157	2,250	30,104	13.38	5
6	CNA Trainees	7,599	7,599	62,385	8.21	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,778	2,062	31,006	15.04	9
10	Activity Assistants	5,754	6,171	57,684	9.35	10
11	Social Service Workers	449	728	13,654	18.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,814	2,120	46,536	21.95	14
15	Cook Helpers/Assistants	20,238	21,818	242,895	11.13	15
16	Dishwashers					16
17	Maintenance Workers	3,680	3,958	64,580	16.32	17
18	Housekeepers	30,157	32,212	368,555	11.44	18
19	Laundry	4,917	5,391	55,055	10.21	19
20	Administrator	1,784	2,080	92,465	44.45	20
21	Assistant Administrator	1,947	2,080	81,439	39.15	21
22	Other Administrative	1,816	2,091	36,714	17.56	22
23	Office Manager	1,834	2,080	48,279	23.21	23
24	Clerical	5,961	6,135	68,355	11.14	24
25	Vocational Instruction					25
26	Academic Instruction	1,800	2,080	39,766	19.12	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,333	15,216	239,115	15.71	28
29	Resident Services Coordinator	1,886	2,080	37,144	17.86	29
30	Habilitation Aides (DD Homes)	130,452	142,083	1,479,946	10.42	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	251,515	272,480	$ 3,373,503 *	$ 12.38	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 7,307	L1, C3	35
36	Medical Director	96	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	12	338	L10, C3	38
39	Pharmacist Consultant	48	3,240	L10, C3	39
40	Physical Therapy Consultant	41	2,269	L10A, C3	40
41	Occupational Therapy Consultant	100	5,514	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	158	8,977	L10A, C3	43
44	Activity Consultant	732	45,061	L11, C3	44
45	Social Service Consultant	129	6,438	L12, C3	45
46	Other(specify)				46
47	Psychologist	9	780	L10, C3	47
48	Psychiatrist	12	2,400	L10, C3	48
49	TOTAL (lines 35 - 48)	1,502	$ 94,324		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,373	$ 71,289	L10, C3	50
51	Licensed Practical Nurses	2,232	103,361	L10, C3	51
52	Certified Nurse Assistants/Aides	2,240	49,502	L10, C3	52
53	TOTAL (lines 50 - 52)	5,845	$ 224,152		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	0.00	$ 92,465
Barbara Waters	Asst. Administrator	0.00	81,439
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 173,904

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planner, Inc.	U/C Consultants	$ 3,775
Shaw, Gussis, Fishman, Glantz	Legal	33,715
Shefsky Froelich Ltd.	Legal	56,741
Warady & Davis LLP	Accounting	26,000
Wildman, Harrold, Allen & Dixon	Legal	198,971
Winston & Strawn	Legal	5,397
United States Dept. of Justice	Bancruptcy Fee	16,000
Urban Real Estate Research	Appraisal	6,000
Wiss, Janny, Elstner Associate	Legal	9,832
Foley Lardner	Legal	12,727
Duetsch, Levy & Engel	Legal	26,185
See Schedule 21a Attached		4,979
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 400,322

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,197
Unemployment Compensation Insurance	51,728
FICA Taxes	258,412
Employee Health Insurance	146,535
Employee Meals	39,271
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	82,530
Other Employee Benefits	43,310
TOTAL (agree to Schedule V, line 22, col.8)	$ 716,983

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 9,990
Advertising: Employee Recruitment	54,483
Health Care Worker Background Check	
(Indicate # of checks performed 149)	2,956
Illinois Health Care Association	210
Secretary of State	1,439
Cook County Departments	769
Miscellaneous Licenses and Fees	4,917
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 74,764

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,448
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,448

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2005

Schedule 21a

Page 21 - Professional Services

Vendor/Payee	Type	Amount
SAS Architects & Planners	Architect	4,254
Hunter Benefits Consulting	Benefit Plan	250
North Central Land Survey Company	Surveyor	475
		4,979

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healh Care Assoc ($7,452)**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,134** Line **Line 10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ **419,862**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **39,271** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **1,439**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.